

FEDERAL BUREAU OF INVESTIGATION  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-002712**

STATE FILE NUMBER

FILED VS JAN 28 1960 **467**

Primary Registration District No. **3049**

Registrar's No. **3**

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>PEMISCOT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>NEW MADRID</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HAYTI</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>CONRAN RURAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MEMORIAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>SAM TIE</b> Middle <b>POOLE</b> Last				4. DATE OF DEATH Month <b>JAN</b> Day <b>3</b> Year <b>1960</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>black</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 4, 1913</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months <b>29</b> Days	IF UNDER 24 HR Hours <b>8</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (City and state or country) <b>Hayti, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Buddy Poole</b>			13b. MOTHER'S MAIDEN NAME <b>Louise Brown</b>			14. NAME OF HUSBAND OR WIFE <b>Sadie Haynes Poole</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>486-46-6653</b>		17. INFORMANT Address <b>Sadie Poole Portageville, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>3 January 1960</b> to <b>3 January 1960</b> and last saw him alive on <b>3 January 1960</b> Death occurred at <b>8:15 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Andrew E. Painter M.D.</b>				22b. ADDRESS <b>Portageville Missouri</b>				22c. DATE SIGNED <b>11 Jan 60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Portageville</b>		23d. LOCATION (City, town, or county) (State) <b>Portageville, Missouri</b>				
24. FUNERAL DIRECTOR <b>DeLisle Funeral Home Portageville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Jan. 11 - 60</b>		26. REGISTRAR'S SIGNATURE <b>Dr. Donald Adams</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 28 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Joseph A. [Signature]*

Licensed Embalmer No. 4481

P. O. Address Wagwell

Note: The above, MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.